AOG FINANCIAL POLICY

We hope to make your visits in our office as thorough and pleasant as possible. We also want you to have a full understanding of our financial policies and expectations for payment of services. Please carefully review and sign our financial policy, and let us know of any questions you may have.

The primary and final relationship is between the physician and you (the patient) and our contract is with you. We will not compromise your medical care to satisfy ANY insurance company. Bear in mind, insurance is meant to help defray the cost of medical care and is NOT intended to dictate your treatment.

Payment is due and expected in full at the time services are rendered unless other arrangements are made **PRIOR** to your appointment. This includes deductibles, copayments, coinsurance and non-covered services.

If you are scheduled for your annual gynecological exam that is how your insurance carrier will be billed. If during your encounter with your provider additional problems and/or concerns are found, we can schedule another appointment to address your problems or we can treat those problems and/or concerns concurrently with your annual exam, however, there will be an additional charge for that service.

As a courtesy we are happy to assist you in the filing of most insurance claims, completing insurance forms, and insurance precertification. You will be responsible for any and all balances not covered by your insurance. If your insurance has not paid their portion within 60 days of being properly billed, the entire balance will be your responsibility. If you are unsure of any specific requirements of your insurance, **PLEASE ASK THEM**. We are unable to be completely familiar with every type of insurance and plan. As the insured client, you are in the best position to follow up and exert pressure on your insurance carrier to ensure payment is being processed. Due to stricter guidelines from insurance carriers and the Office of the Inspector General we are unable to change charges after they have been submitted to your insurance carrier.

In signing this form you, the patient, authorize payment be made to Associates in Obstetrics & Gynecology, PC. You also authorize the release of any medial information, about yourself, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS confidential information to my insurance carrier and/or Centers for Medicare and Medicaid Services (CMS) and its agents and/or my Medigap insurer that are necessary to determine these benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this authorization will be considered as effective and valid as the original.

You will receive a monthly statement requesting payment on any unpaid balance. If your account becomes past due, please contact our office to discuss payment arrangements and to avoid further collection efforts. We are committed to being sensitive to patient financial difficulties, but we are unable to assist you if you do not contact us to discuss your account. If payment is not made for our services, we may turn the account to an outside collection agency. In the event that your account is placed with an outside collection agency you will be responsible for the cost of collection, including but not limited to attorney fees, court costs, and applicable collection fees.

There is a fee (currently $30) for any check returned by the bank. Patient balances that go unpaid for 90 days or more will incur additional interest charges of 1% per month or 12% APR. Appointments not cancelled with at least 24 hour notice will incur a charge of $50 for time reserved. In an effort to utilize the time of our doctors and the operating room, your account will be charged a fee of $200.00 if you cancel your surgery or procedure within two weeks of the date of your surgery.

I have read and understand the financial policy of AOG, I acknowledge it is my responsibility to ensure payment of fees for services provided by AOG and I agree to be bound by its terms.

_____ _____

Print Patient Name Signature of Patient or Responsible Party and date